No. 2
11-10-39
5-17-39
I X21492

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH V

State File No. 8338

FILED MAR 11 1940

Registration District No. 8-34 Primary Registration District No. 45-03 Registrar's No. 5

1. PLACE OF DEATH
(a) County Stoddard
(b) City or town Advance
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: V
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
(Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Stoddard
(c) City or town Advance
(If outside city or town limits write "RURAL")
(d) Street No.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME David L. Looney

3. (b) If veteran, name war No

3. (c) Social Security No.

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Ethel Looney

6. (c) Age of husband or wife if alive 46 years

7. Birth date of deceased (Month) Aug (Day) 15 (Year) 1874

8. AGE: Years 65 Months 5 Days 22 If less than one day hr. min.

9. Birthplace Mc Kendree (City, town, or county) Illinois (State or foreign country)

10. Usual occupation Rural Carrier & Farmer

11. Industry or business

MOTHER FATHER

12. Name Stephen A. Looney

13. Birthplace Kentucky (City, town, or county) (State or foreign country)

14. Maiden name Elizabeth Gilbert

15. Birthplace Illinois (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Ethel Looney

(b) Address Advance, Mo. R.F.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 10 1940 (Month) (Day) (Year)

(c) Place: burial or cremation Morgan Memorial Park

18. (a) Signature of funeral director Lloyd L. Berger

(b) Address Advance, Mo

19. (a) 2/22/40 (Date received by registrar) (b) D. S. McKee (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 7
year 1940 hour 2 minute 45 A.M.

21. I hereby certify that I attended the deceased from Dec 39, to Feb. 7, 1940; that I last saw him alive on Feb 7, 1940; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Tuberculosis with asthma	
Due to: and Bronchitis for 30 years	
Due to:	
Other conditions (Include pregnancy within 3 months of death)	

PHYSICIAN

Major findings:
Of operations
Of autopsy

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury 2

23. Signature E. C. Masters (M. D. or other) M.D.
Address Advance, Mo Date signed Feb 10 1940

1-0 (Licensed Embalmer's Statement on Reverse Side)

238

RECEIVED
District Health Officer No. 2
District File Number 340 - 712
Date Filed 3/8/40

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed Lloyd D. Morgan

Licensed Embalmer No. 3361

P. O. Address Advance, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

o. No. 2B
—2-21-40
I X22659

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 8338 Y

Registration District No. 834 Primary Registration District No. 45-05 Registrar's No.

1. PLACE OF DEATH:
(a) County Stoddard
(b) City or town advance
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(If outside city or town limits write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME David L. Looney
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 65 Months 5 Days 12 If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

SUPPLEMENTARY

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 7
year 1940 hour minute M.
21. I hereby certify that I attended the deceased from , 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Tuberculosis Pulmonary Asthma and Bronchitis for 30 yrs	
Due to Lungs or Pulmonary	
Due to Tuberculosis	
Other conditions (Include pregnancy within 3 months of death) 72	
Major findings: Of operations	
Of autopsy	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? (Specify type of place) (e) Means of injury

23. Signature E. C. Masters (M. D. or other)
Address advance Mo Date signed